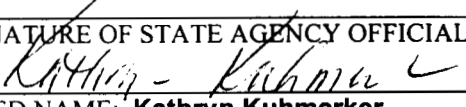
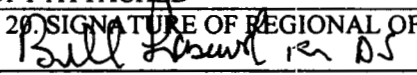


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 04-27	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2004	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 CFR, Part 447, Subpart C		7. FEDERAL BUDGET IMPACT: a. FFY 2003 – 2004 \$0 b. FFY 2004 – 2005 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Part I, Page 248		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A, Part I, Page 248	
10. SUBJECT OF AMENDMENT: Inpatient Hospital Services			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Office of Medicaid Management Corning Tower - Empire State Plaza Room 1466 Albany, New York 12237	
13. TYPED NAME: Kathryn Kuhmerker			
14. TITLE: Office of the Deputy Commissioner Department of Health			
15. DATE SUBMITTED: June 30, 2004			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: 3-7-05	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2004		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: William Lasowski		22. TITLE: Acting Deputy Director, CMSO	
23. REMARKS:			

**New York
248**

**Attachment 4.19-A
Part I
SPA #04-27
(04/04)**

Graduate Medical Education - Medicaid Managed Care Reimbursement

[Effective January 1, 1996, t] Teaching hospitals shall receive direct reimbursement from the State for graduate medical education (GME) costs associated with inpatient services rendered to patients enrolled in Medicaid managed care or Family Health Plus plans.

Each teaching hospital will be paid an average per discharge amount for each Medicaid managed care or Family Health Plus patient discharged from the hospital. [using the latest average Medicaid case mix as follows:] The average per discharge amount will be based on the estimated GME reimbursement included in the current rate year's Medicaid inpatient rates of payment for each facility determined on a case mix neutral per discharge basis for both case based payments, including outlier payments, and the exempt unit rate type.

Case based payment rates including outlier payments will be adjusted by each hospital's case mix for Medicaid managed care patients and Family Health Plus patients, using the case mix data reported to the Department for the twelve month reporting period two years prior to the rate year.

Exempt unit rates will be adjusted by each hospital's exempt unit average length of stay based on the latest available data reported on the Institutional Cost Report for the reporting period two years prior to the rate year.

[Initial payments will be based on the estimated GME reimbursement included in the 1996 inpatient rates of payment for each facility determined on a case mix neutral per discharge basis for both case payment including outliers and the exempt unit rate type.]

Hospitals shall submit data to the [department] Department of Health including the actual case mix of each Medicaid managed care or Family Health Plus patient discharged, the final payment amount for services rendered by the hospital and, for exempt units, the [days of care rendered by the hospital] actual length of stay.

[Initial p] Payments [will] may be reconciled using the actual case mix of the Medicaid managed care and Family Health Plus patients discharged from the hospital when the necessary data is received and finalized [, however, the reconciliation shall be completed within two (2) years from the date of discharge].

TN 04-27

Approval Date MAR - 7 2005

Supersedes TN **Effective Date** APR - 1 2004